PRESIDENTIAL ADDRESS

From the Society for Clinical Vascular Surgery

Academic medicine or private practice: You can't tell the players without a scorecard

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It has been both an honor, and a pleasure, for me to serve as your president for the past year. It is an experience for which I will be forever grateful. As practicing vascular surgeons, you are all too familiar with the sacrifices that we impose upon our families in order that we may pursue a career in medicine. We uproot our spouses and children so that we may obtain the "best training," and then we uproot them again, in some cases several times, in an effort to advance in the academic world, or to find the "perfect job." I owe my family a tremendous debt of gratitude, which I will never be able to adequately repay. Although professional accomplishments are satisfying, it is my family that makes my life worthwhile. Thank you to my daughter Rachel, and her husband Steve Meltser, to my son David who could not be here because he is in law school in Los Angeles, and to my granddaughter Hannah and my grandson Avi. As for my wife Susan, you have been my true companion on the road of life, without whom none of this would have been possible. I thank you and I love you.

Recently, much has been written concerning the critical role of mentoring in the development of a surgeon. I have been exposed to many excellent teachers in my career. However, there are three that I consider as my mentors. The first is my father, Dr Eli Brown. To go through his resume would take up the remainder of the time allotted for my Presidential Address. Suffice it to say that he taught me early in my medical career the importance of academic pursuits. He stressed to me that taking care of patients, while important, was not the only component of being a physician. He recommended that I read at least one article every day. The length of the article was unimportant. At the end of the year, I will have read at least 365, and during a leap year, 366 articles. That is a lot of information obtained in a relatively painless manner. A second piece of advice he gave me was "Remember, 95% of the patients you take care of will get better, in spite of what you do to them." No truer words were ever spoken.

My two other mentors were Dr William S Blakemore, a past president of the International Society for Cardiovascular Surgery, with whom I completed my general surgery residency, and Dr Larry Hollier, a past president of this society, with whom I completed my vascular fellowship. These men taught me the importance of excellence, and to neither accept nor pursue anything less. They also reinforced my father's belief that there was more to the practice of medicine than simply taking care of patients. Dr Blakemore helped me to write my first paper, and Dr Hollier helped me with my first major presentation. I will be forever indebted to these men for helping to shape my medical career. As Sir William Osler said, "No bubble is so iridescent or floats longer than that blown by the successful teacher."

One of the first questions that I was asked, when I was applying to vascular surgery fellowships almost 30 years ago, was whether I was interested in becoming an academic vascular surgeon or a private practice vascular surgeon. This was a question that required a very carefully crafted response, for it was well known that some of the best programs had decided to train only those individuals who were interested in becoming full-time "academic vascular surgeons." I knew that I wanted to be involved in a teaching program and also wanted to do clinical research, but I was not particularly interested in pursuing basic science research. Therefore, I was not certain that I wanted to be employed by a university. Quite honestly, as a surgical resident, and a fellow, I had already had the honor of being the low man on the totem pole in a university program. Although being junior faculty was definitely a step above being a resident or a fellow, in those days, it was not exactly a giant step. Trying to balance my desire to be selected to train at one of the better institutions, with my need to be reasonably honest and truthful, I often answered by saying that I wanted to be involved in an academic program, which included teaching residents and pursuing clinical research.

From the William Beaumont Hospital and Wayne State University School of Medicine.

Competition of interest: none.

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Not surprisingly, many of the candidates that currently interview for a position as a vascular fellow in our program give me that exact same response. To date, no one has told me, "I don't want to teach, I don't want to write, I just want to do cases and make money." A few have responded that they want to work as full-time university surgeons. The overwhelming majority state that while they do not want to be full-time university surgeons, they do want to teach, write papers, and practice in an academic private practice setting. I used to believe that I knew exactly what this response meant, but now I am not so sure. I have often wondered how many of the candidates who said they wanted to be an academic private practitioner had any idea of the commitment involved in pursuing that type of medical career.

Perhaps we should begin with some basic definitions. The Oxford Encyclopedia of English defines academic as scholarly, "to do with learning."[1] Scholarship is defined as "learning of a high level."[1] You will note that the term university does not appear in either of these definitions. Accordingly, membership on a university faculty, while conducive to scholarship, is not mandatory for the practice of academic medicine. Curiously, medicine is the only profession in which a distinction is made between those individuals who practice as full-time members of a university faculty, the so called "academic surgeons," and surgeons who practice in a community based setting, often referred to as "private practice surgeons." We do not differentiate between private practice and academic accountants or private practice and academic attorneys. Similarly, we do not refer to nurses who work at a university hospital as academic nurses as opposed to private practice nurses who work at a community hospital. Why have physicians chosen to place so much emphasis on this apparent, if not real, distinction? Furthermore, what criteria has the medical profession chosen to define each of these categories?

As in many cases, we simply need to look to the stereotypic description of the academic and the private practice physician to identify the key perceived components of each category. Everyone knows that academic surgeons are well read and up to date on the latest publications. However, academic surgeons are presumed to be incompetent in the operating room, while at the same time, excellent animal and rat surgeons. Academic surgeons come in at 9:00 AM and go home at 4:00 PM. They are paid by the university and have no need to do cases to generate their income.

Alternatively, private practice surgeons, while technical magicians, unfortunately have no concept of the basic tenets of surgical indications, and have not only never written a paper, have probably never read one either. They make inordinate amounts of money and have no interest in teaching students or residents. They are primarily interested in accumulating wealth and living the good life. The alleged mantra of the private practice surgeon is "Those that can, do, those that can't, teach."

Interestingly, these stereotypes have (hopefully unwittingly) been endorsed by the American College of Surgeons. In the publication "So You Want to be a Surgeon," section II, number 1 is entitled "Academic vs Community based Private Program?" The first sentence states, "There are a number of fine nonacademic programs that will adequately prepare you for community practice. . . ."[2] This is not exactly a ringing endorsement. Does the American College of Surgeons really believe that the ACGME would accredit a "nonacademic" program? The section concludes by outlining the advantages of academic programs, including an emphasis on teaching, the ability to work in situations (VA hospitals), which provide a better opportunity for supervised independence and cross pollinization with other residents. As a further shot across the bow of community or nonacademic programs, under number 2, the publication states that if you do not attend an academic program, you "may encounter some barriers and biases when applying for a fellowship."[2] These stereotypes are also perpetuated in the medical literature. A recent article published in the journal *Surgery* was entitled, "Turning medical students on to the fun and excitement of a true, broad-based general surgery practice in the community outside the ivory tower."[3]

As with most stereotypes, there are individuals who do fit these descriptions. However, the overwhelming majority of surgeons are a hybrid of the descriptions I have given. In fact, you can't tell the players without a scorecard.

If we were to obtain such a scorecard, how would it distinguish between these two groups of surgeons? Perhaps the first thing we need to do is eliminate the arbitrary use of the term "private practice surgeon." A better designation would be "community hospital based surgeons" and "university hospital based surgeons." Each of these groups is composed of both academic and nonacademic surgeons. Some would argue that private practice surgeons are those who bill for their procedures and rely totally upon their practice for their income. Yet today, most surgeons in a university based program are also dependant to a large extent upon their clinical productivity for their income. As the old saying goes, "there is no free lunch." If this is the case, how do we explain the alleged disparity between the incomes of university based surgeons and community hospital based surgeons?

It is explained quite easily. It does not exist. Data from 2006 published by the Medical Group Management Associations reports the following incomes for community hospital based or so called private practice surgeons.[4] The mean income was \$282,690. The 25th percentile was \$186,421, and the 90th percentile was \$445,446.

Comparable numbers for university-based vascular surgeons were a mean income of \$287,126. The 25th percentile was \$219,374 and the 90th percentile was \$420,775. This has been further broken down by academic rank. Mean compensation for an assistant professor was \$220,501, for associate professor \$320,399, and for full professor, \$331,603. For those junior faculty who are wondering what the chief is making, the mean is \$362,734 with a 25th percentile of \$311,603 and a 90th percentile of \$542,537. To paraphrase Mel Books in the movie *History of the World Part I*, "It's good to be the chief." It is quite

clear from these number that the presumed crevasse between the income of university based and community hospital based vascular surgeons does not exist.

Let us now examine operative ability. I have had the opportunity to work in both a university based and community based setting. I have seen outstanding technical surgeons in both arenas. I have observed surgeons in both settings who leave a great deal to be desired from a technical standpoint. The hospital in which you practice does not determine or define your technical abilities. My own bias is that the overwhelming majority of surgeons fit into the same category, technically competent. While I have been privileged to operate with some surgeons blessed with remarkable dexterity, any surgeon who knows his or her anatomy and has reasonably good judgment should be a technically adequate surgeon. Thus, technical dexterity is not on the scorecard.

If income and technical ability are not determinative factors, what are the key components that determine whether a community based or a university based surgeon is labeled an academic or a nonacademic surgeon? The key components are analogous to the three legs of a stool, with teaching, research, and clinical activity forming the foundation. When we speak of teaching, we are referring primarily to the teaching of medical students and residents. Teaching should not be confined to a specific venue such as the operating room, or conferences, but should pervade every interaction between the attending surgeon and his resident or medical student. Certainly, there are some community hospitals that do not have residents or students. Does that preclude surgeons in these hospitals from being academic surgeons? It should not. Teaching may take many forms including the teaching of nurses, physician assistants, and operating room personnel. It is one of the most important ways that we as physicians can give back to our profession and to those who took the time to instruct us. There is a Latin proverb which states "By learning you will teach and by teaching you will learn."

Many individuals rely upon research as the key distinguishing component between an academic and a nonacademic surgeon. However, like teaching, research may take many different forms. At one end of the research continuum are those surgeons who may be characterized as clinician-scientists.[5] These are surgeons who dedicate a significant portion of their professional time to the pursuit of basic science research. They often obtain funding from outside sources, including the National Institute of Health. Although nonacademic surgeons may derogatorily refer to these individuals as "rat surgeons," no one can deny the valuable contribution that these clinical scientists have made to our specialty and to the field of medicine in general. At the other end of the continuum are those surgeons who publish case reports. Although not as impressive as a RO1 grant, case reports, too, provide a valuable contribution to the medical literature and should be considered as fulfilling the goal of performing research. For many surgeons, clinical research takes the form of either a prospective or retrospective review of the results of their clinical activity. In truth, it is incumbent upon all surgeons to perform this type of clinical research in that all surgeons should, at the very minimum, be familiar with their own surgical results. The days of quoting other peoples results from the literature are gone. Even the lawyers have adopted this concept. In the case of *Johnson v Kokemoor*, the court ruled that a neurosurgeon who quoted results from the literature, and not his own results, did not provide his patient with adequate informed consent.[6] In his presidential address to the Society for Vascular Surgery, Dr Norman Hertzer declared, "Results mean everything."[7] I would humbly add, and you had better know your own.

As for the third leg of the stool, clinical activity, a surgeon who does not operate can never truly be considered an academic surgeon. Therefore the question arises: How many cases does a surgeon have to perform to qualify as an academic surgeon? While a surgeon must spend some time in the operating room to be considered an academic surgeon, in truth it is not the number of cases performed, but rather the surgeon's involvement in the preoperative decision making and the postoperative care that often defines a surgeons clinical activity. As we all know, the hardest questions are often on whom and when to operate. The actual technical exercise, while both challenging and rewarding, is just that, a technical exercise. Therefore, it is not the signature on the bottom of a surgeons paycheck, or the institution where the surgeon performs his/her surgery that determines whether the surgeon is an academic or nonacademic surgeon, but rather the sum total of his/her clinical and educational pursuits that must be relied upon to make such a determination.

We have defined an academic surgeon, but how do we define an academic surgery department? University based practices have a significant advantage in developing an academic department. One significant difference between university based and community based vascular surgery departments is the stability of the department. Community based vascular surgery departments, by their nature are most often composed of several different individuals or groups and, therefore, tend to fluctuate more than university based departments. The individual members of a community based department of vascular surgery eventually retire from practice, or the groups of vascular surgeons that compose the department all too often break apart. Under these circumstances, it is difficult for the community based vascular surgery department to sustain, over long periods of time, a consistent academic agenda. On the other hand, the university based vascular surgery department, being essentially one group consisting of multiple individuals, enjoys the inherent advantage of stability. In addition, all members of the university based department have, at least tacitly, agreed to pursue the same educational goals. While its members may change, the department's goals and ideals are more easily sustained. We should therefore acknowledge that while a community based surgeon may readily qualify as an academic surgeon, it is much more difficult for a community based department to qualify as an academic department.

Must a vascular surgeon choose between becoming a member of a university based or a community based department, or can he/she practice part time in both settings? In the past, practicing in both settings would have been impossible. Most academic chairmen, based upon their perception that no one individual could comfortably fit into both of these practice settings, would have flatly rejected this idea. However as Bob Dylan noted, "The times they are a changing." A recent article by Sanfey et al, from the University of Virginia Health System in Charlottesville, found that contrary to the author's initial hypothesis, surgery department chairs appeared to be supportive of part-time clinical faculty.[8] An academic vascular surgeon is an academic vascular surgeon, and he/she can be an important asset to both a community based and a university based vascular surgery department.

As a specialty, what can vascular surgery, and we as vascular surgeons do to insure that our fellows who complete a vascular surgery training program remain academic vascular surgeons? First, we must continually reinforce to our trainees and colleagues the importance of not only knowing one's own results, but also of participating in registries. We must do this by example by participating in the registries offered by the Society for Vascular Surgery, as well as registries offered by our state and local societies. If your hospital does not have a registry, start one. Vascular surgeons must continue to insist upon evidence based medicine. As such, it is imperative that we record and publish our results with various open surgical and endovascular techniques. This must be done with integrity and equipoise. Otherwise, we will be no better than the "snake oil salesman" of the past.

We must encourage our colleagues to participate in local, regional, and national meetings such as the Society for Clinical Vascular Surgery. There is no more appropriate place to exchange ideas, and at the same time, consider the topic for your next research project. Vascular societies must solicit active participation from all of their members, not just the senior or university based members, but from all vascular surgeons, whether they are university based or community based surgeons. Involvement of our entire membership will serve to strengthen our society as well as our specialty.

Vascular Surgery has a bright future, and I look forward to sharing that future with both the university based and community based academic surgeons that compose the membership of the Society for Clinical Vascular Surgery.

REFERENCES

1. Oxford Encyclopedia of English, Third Edition, New York, : Oxford University Press, 1996.
2. Johansen K, Heimbach DM. "So, You Want To Be A Surgeon. . ." in a medical student's online guide to finding and matching with the best possible surgical residency. American College of Surgeons, Copyright 2001-2007.
3. Rowekamp JD. Turning medical students on to the fun and excitement of true, broad-based general surgery practice in the community outside the "ivory tower." Surgery 2003;134:418-9.
4. Medical Group Management Association. Academic Practice Compensation and production Survey for Faculty and Management, 2006 Report.
5. Brand RA, Hannafin JA. The environment of the successful clinician-scientist. Clin Orthop Relat Res 2006;449:67-71.
6. *Johnson v Kokemoor*, 199 Wis.2d 615, 545 N.W.2d 495 (Wis. 1996), 320, 328.
7. Hertzer NR. Outcome assessment in vascular surgery-results mean everything. J Vasc Surg 1995;21:6-15.
8. Snafey H, Savas J, Hollands C. The view of surgery department chairs on part time faculty in academic practice: results of a national survey. Am J Surg 2006;192:366-71.

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